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The Brain Did It: Substance Abuse and States

New Hampshire State Rep. Peter Batula is trying to figure out how to protect the people of his state from illicit drugs. Columbian drug lords are flooding New England with 90 percent pure heroin, he said, and a lot of that heroin is being bought by high school kids, for only $2 to $3 a shot.

"Very frankly, in at least one school, they don't think they have a problem," he said. "They have a plainclothes policeman in the school, and the attitude is, just catch them (kids who possess illegal drugs) and get them out of here."

Batula would like to send the kids who become addicted to long-term treatment. But doing that wouldn't be easy, he said. "I don't think we take long-term treatment very seriously," he explained. "In general, I think we look to punish people."

Historically, the public has responded to substance use with punishment, rather than treatment. But experts in addiction say there's more to achieving sobriety than simple willpower. During a three-day conference held in Washington, D.C., by NCSL's Health Chairs' Project, nationally recognized experts in addiction hammered home two messages:

1) Addiction to alcohol or other substances is, essentially, a chronic, relapsing brain disease. While the first drink or injection may be voluntary, the continued use of a mind-altering substance literally alters the landscape of the brain.

2) Treatment works, but it's unrealistic to expect that one episode of treatment will cure the patient. Like all patients with chronic diseases, the addict has to receive continuing treatment after the initial detoxification or rehabilitation. Without ongoing treatment, the likelihood of relapse is high.

"People say it is the individual who decides to take the drug and therefore, it (addiction) is not a disease process," said Nora Volkow, M.D., director of the National Institute on Drug Abuse (NIDA). "But how is that different from the person who decides to smoke a cigarette and ends up with lung cancer? No one, no one, and I've been treating drug-addicted people for the past 20 years, decides to become addicted."

"It's tough to be compassionate (by providing treatment) to someone who's injecting methamphetamine and abandoning their children," said Tom McLellan, PhD, director of the Treatment Research Institute in Philadelphia. But "compassion" can help an addict remain sober, and it makes good economic sense.

The 1994 "Evaluating Recovery Services: The California Drug and Alcohol Treatment & Assessment" study showed that every dollar spent on treatment of drug and alcohol use saved state residents $7. The level of criminal activity in the population studied decreased by two-thirds from before treatment to after treatment, and the longer participants remained in treatment, the greater was the reduction in criminal activity.

A HIGH COST TO STATES

Substance abuse is a critical issue for states, and not only because of the heavy toll on human lives. There's a huge dollar figure attached. According to the Institute of Medicine, alcohol and substance use disorders (including nicotine addiction) cost the U.S. $256.8 billion a year. That dwarfs the costs of heart disease ($133.2 billion) and cancer ($96.1 billion).

In 2001, the National Center on Addiction and Substance Abuse (CASA) at Columbia University in New York City published the most comprehensive analysis yet of how much states spend on alcohol and substance use disorders. CASA found that states spent $81.3 billion on this issue in 1998 – 13.1 percent of their budgets.

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FOCUS ON...

Palliative Care Networks Improve End-of-Life Care in NYC

While many people say they would like to die at home, nearly 70 percent of deaths occur in hospitals and nursing facilities. Palliative care — which extends the principles of hospice care to a broader population, providing comfort and improving the quality of life earlier in the disease process — exists in community settings, but it is frequently fragmented and inconsistent. The lack of quality, or lack of services, can force individuals out of their homes and into hospice and hospital settings for their final days. Sometimes, because of medical advances, these "final days" can turn into weeks, months or even years.

Recognizing that palliative care needs to be improved, particularly in home-based environs, the United Hospital Fund in 2000 launched the Community-Oriented Palliative Care Initiative (COPCI). The three-year, $2.5 million program sought to devise a new approach to identifying and caring for people in New York City with terminal illnesses. The funding that COPCI provided helped to establish or improve collaborative networks, or partnerships among clinicians, nurses, hospitals and social service agencies dedicated to improving the quality of life for those at the end of their lives.

The idea of the collaborative network came from the realization that patients, particularly those ineligible for in-hospital hospice care, were often discharged into their communities with only limited direct care (pain and symptom management) and social support services. As a result, "home-based palliative care was often initiated late in the course of an illness, if at all," explained David Gould, senior vice president for programs at the United Hospital Fund. The goals of the COPCI initiative were to "reach dying patients farther upstream in their illnesses," while finding ways to replace fragmented services "with a seamless array of assistance and support," said Gould.

In March 2004, the Fund released *Moving Palliative Care into the Community: New Services, New Strategies*, an evaluation of the effectiveness of the networks in providing end-of-life care services. The bottom line is that community-based palliative care networks can provide comprehensive and flexible end-of-life care that improves the quality of life for people with terminal illnesses.

Altogether, six networks were either formed or assisted by COPCI. Each network was awarded a two-year, $350,000 development grant; services were typically launched after a 10-to14-month planning period.

Four of the networks were new – the Catholic Healthcare System, Harlem, Mount Sinai and Southern Brooklyn palliative care networks. Two other, existing projects – the Bronx and the Queens palliative care networks – sought to improve their systems by training primary-care providers who already were providing some component of end-of-life care. The providers were taught how to make a palliative care system effective, and how to make the most of available resources.

The four new networks used a nurse or a nurse-social worker, backed by a physician, to coordinate pain and symptom management, referrals to other clinicians or social service providers, and mediation between patients, family caregivers, physicians and other health-care providers.

The two established networks operated under the assumption that primary-care physicians knew best how to meet their patients' health-care needs and, with some training in palliative care, could work with medical and hospital systems to cost-effectively provide palliative care services.

THE WEAK LINKS

Perhaps the biggest challenge facing the networks was enrolling patients into the program. Each network anticipated being able to enroll roughly 200 patients; all told, the six programs enrolled 500 patients (ranging from 15-208 per site), each of whom received three to six months of services, referrals and support. Factors influencing the disappointing rates of enrollment included: eligibility criteria, accessibility of patient populations and poor rates of referrals from providers.

COPCI found that networks with broader enrollment criteria assisted more patients than did networks with narrow criteria. For example, Mt. Sinai's network, which enrolled 39 patients, limited its patient population mostly to those with primary diagnoses of congestive heart failure or lung disease and to patients over age 80 with dementia who had been admitted for pneumonia. In contrast, the Harlem network offered services to anyone over age 18 who suffered from any progressive, life-threatening illness, including cancer, heart and lung disease, HIV/AIDS and end-stage renal disease. The Harlem network enrolled 208 patients.

In addition, enrollment was stymied by the fact that physicians were reluctant to refer their patients to palliative care. "The expectation that primary-care providers would refer patients to the network simply wasn't borne out," Gould noted. Many physicians were unaware of the nature of palliative care and of the network's potential benefits to patients. Physicians feared that they would lose their patients, and they were unwilling to undertake the administrative requirements of referring patients to the networks. "Winning over physicians was essential," said Gould.

THE KEY TO SUCCESS

Nevertheless, the report states that a number of valuable lessons were learned about the organization, scope and sustainability of an ideal community-oriented palliative care network.

The report concludes that networks with the following components are more likely to succeed: a simple enrollment process; ongoing assessment of the needs and concerns of patients and families; patient and family education; pain medication management and other direct care services; advance planning for end-of-life care; ongoing communication with a primary-care physician; emotional support for patients and their families; an effective referral network for services beyond the palliative care domain; and, ongoing outreach to community organizations and providers to increase referrals and enhance the coordination of services for patients and families.

"We weren't about trying to create a model network," said Gould. Instead, the goal of COPCI was to help participating clinicians and providers become "aware of the issues in providing palliative care within their own organizational structure and their own set of resources," he explained. Each program "grappled with very different issues," including enrolling and maintaining patients in their program, developing a model to ensure the seamless delivery of services, and educating physicians about the nature of palliative care. In the end, the exercise "provided a powerful example of the importance of having community resources in place to address end-of-life issues, many of which are not clinical," he added. *+ACS*

For more about COPCI , call (212) 494-0700 or log onto www.uhgnyc.org

HIGHLIGHTS

LONG-TERM CARE

Protecting Against Fire

Tennessee is about to become the first state ever to require all nursing homes to have full fire-sprinkler systems, according to an article in the *Tennessean*. The state suffered a number of deadly nursing home blazes last year, including one that killed 14 in Nashville. The General Assembly made sprinkler legislation a high priority this year, and legislators started out with more than a dozen sprinkler-related bills, before passing three key ones. Brian McGuire, state legislative director for AARP, told the *Tennessean* that multiple fire deaths rarely occur in long-term care facilities that have fully operating sprinkler systems. The state budget includes nearly $320,000 this year and a total of $17 million in state and federal funds over the next four years to help nursing homes retrofit. As a first step, every nursing home must have smoke detectors in every patient room by early August.

Inadequate Staffing

More than one-third of California's free-standing nursing homes did not meet the state's minimum nurse staffing standards (3.2 hours or more per resident, per day), according to a new report from the California HealthCare Foundation. Although more homes met the minimum standard in 2002 than in 2001, the low staffing levels contributed to more than two-thirds of the nursing home staff leaving their jobs in 2002. Low staffing and high turnover rates contributed to poor quality of care and a 38 percent increase in complaints between 2000 and 2002. In 2002, 10 percent of nursing home residents experienced significant weight loss; 9 percent were in bed all or most of the time; and 17 percent were placed in physical restraints. For copies of "Nursing Homes: A System in Crisis," go to www.chcf.org.

MEDICARE

A Mixed Beginning

By the end of May, about 2.87 million Medicare beneficiaries had signed up for a Medicare prescription drug discount card (which went into effect June 1). Nearly all those beneficiaries – 2.3 to 2.4 million – had been automatically enrolled by their "Medicare Advantage" or managed-care plan, according to the May 31 issue of *Medicine & Health*. Those figures do not include low-income beneficiaries who are eligible for a credit worth $1,200 over the next 18 months. Tommy Thompson, secretary of the U.S. Department of Health and Human Services, told reporters that he is "somewhat concerned" that not enough low-income beneficiaries – who must have incomes below 135 percent of the federal poverty line – have signed up for the card. So he's committed $4.6 million to help enroll those beneficiaries in the card program. HHS will work with the Access to Benefits Coalition to sign up 5.5 million low-income individuals. The coalition comprises 68 organizations, including the Center for Medicare Advocacy, AARP and the Alzheimer's Association. Seven state pharmaceutical assistance plans are automatically enrolling their low-income members.

Many are Underwhelmed

Meanwhile, there are reports from around the country that the cards aren't catching on. Only one in 10 Oklahoma seniors has applied for a card, according to figures from the Oklahoma State University Gerontology Institute. A recent survey in three Oklahoma cities by the Areawide Aging Agency found that only seven of 311 seniors had applied for the Medicare-approved card. "They don't think the cards will help them that much," Don Hudman, Areawide Aging Agency director, told NewsOK.com. "It's totally confusing," said Terri Hearst, a pharmacist at Canadian Valley Pharmacy in El Reno. "There are too many choices. I don't think we know what's going on." As of early June, AARP, which has more than35 million members, mailed out 326,000 enrollment kits, but had signed up only 4,000 people.

MEDICAL MALPRACTICE

Relief Funded by New Fees

On May 24, the New Jersey Legislature unanimously approved a bill aimed at reducing the cost of medical malpractice insurance for physicians. The legislation will create a $78 million temporary fund to help physicians cover the cost of malpractice insurance premiums, as well as establish stricter guidelines for malpractice lawsuits filed in the state. The bill also outlines incentives to be offered to OB/GYNs who practice in underserved areas, as well as funds to help hospitals provide charity care. To help cover the cost of the subsidies, physicians, attorneys, dentists and chiropractors will pay an annual $75 licensure fee and hospitals and other health-care facilities will be required to pay a $3 per employee tax. The legislation also expands the New Jersey Good Samaritan Act which protects health-care workers who respond to emergencies outside of their normal duties from future civic lawsuits. The bill does not include a provision to cap damages in malpractice lawsuits. Gov. James McGreevey is expected to sign the bill.

MEDICAL MARIJUANA

Vermont Gives the Nod

The Vermont Legislature has become the second in the nation to legalize the use of medical marijuana, according to *The Barre Montpelier Times Argus*. The measure, passed by the Senate on a vote of 20 to seven, allows those suffering from AIDS, cancer or multiple sclerosis to grow up to three marijuana plants in a locked room and to possess two ounces of usable pot. The Department of Public Safety will supervise growers. The bill was sent to Vermont Gov. James Douglas, who had said he would neither sign nor veto it. It automatically became law five days after Douglas received it. "I believe that we owe Vermonters with debilitating medical conditions the very best that medical science has to offer," Douglas said. "Proven science has not demonstrated that marijuana is part of that. Despite that fact, marijuana offers those with the most painful chronic diseases a measure of hope in a time of suffering." Douglas resisted pressure from the White House to veto the politically popular bill. The measure's supporters included the leader of Vermont's Catholics, Bishop Kenneth Angell, who praised the governor for helping to improve end-of-life care. Hawaii's legislature also has legalized medical marijuana.

CHILDREN'S HEALTH

Health Indicators

Twenty-one states and the District of Columbia improved on at least seven of 10 indicators of children's well-being between 1996 and 2001, and an additional 14 improved on at least six, says the annual "Kids Count" report released on June 2. The report, conducted by the Annie E. Casey Foundation, examines 10 indicators of children's health, education, income and family structure to determine the national state of children's well-being and to rank each state. According to the report, Minnesota had the highest overall rank, while Mississippi had the lowest. Nationwide, eight of the 10 indicators improved; two indicators — the rates of low-birth-weight infants and children who live in single-parent homes — worsened, each by about 4 percent. The report found that the rate of low-birth- weight infants increased from 7.4 percent in 1996 to 7.7 percent in 2001. At the same time, the national infant mortality rate decreased from 7.3 deaths per 1,000 live births to 6.8 deaths per 1,000, the report found. However, the report found that the infant mortality rate increased in 11 states and remained about the same in two states. In addition, the number of teen girls between ages 15 and 17 who gave birth decreased in every state, reaching a record low of 145,324 nationwide in 2001. To view the study in its entirety, visit www.aecf.org/kidscount/

PUBLIC HEALTH

Obesity Ranking

Texas children have the dubious honor of being the fattest in the nation, says a study in the June issue of the *American Journal of Public Health*. Researchers from the University of Texas School of Public Health collected data on the weight and height of 6,630 children who attended public schools between 1991 and 2000. Calculating the children's Body Mass Index, the researchers found that 22 percent of fourth graders, 19 percent of eighth graders and 16 percent of 11th graders were overweight; the most recent national survey showed that 15.3 percent of children nationwide are overweight. Researchers also found racial disparities in the percentages of white and minority children who were overweight. According to the study, approximately 30 percent of Hispanic boys in fourth, eighth and 11th grades were overweight, and a similar percentage of black girls in fourth grade were overweight. The strongest predictor of being overweight as an adult is being overweight in childhood. State Health Commissioner Eduardo Sanchez told the *Houston Chronicle* that obesity-related costs in the state will likely increase from $10 billion to $40 billion by 2040.

Smoking Morbidity

The number of diseases linked to cigarette smoking is higher than previously known, and smoking "harms every single organ in the human body," says a report from the U.S. Surgeon General, released May 27. The 900-page report, released 40 years after the first Surgeon General's report on smoking, is based on more than 1,600 scientific studies and links smoking to at least 26 diseases, including some that were not previously linked to smoking. The report concluded that that smoking contributes to cancers of the kidneys, pancreas, stomach and uterine cervix; acute myeloid leukemia; abdominal aortic aneurysm; cataracts; periodontitis; and pneumonia. The report also found that smoking may not cause breast cancer but may heighten some women's risk based on their genetic predisposition. In addition, nicotine is found in the breast milk of women who smoke and infants exposed to secondhand smoke are twice as likely to experience sudden infant death syndrome as those not exposed. Women who smoke die on average 14.5 years before women who do not smoke; men who smoke die roughly 13 years before men who don't smoke. Over 400,000 Americans die of smoking-related diseases each year, and the habit costs the nation $75 billion per year in direct health-care costs and $82 billion in lost productivity.

MENTAL HEALTH

Treatment Inadequate

According to a June 2 study released in the *Journal of the American Medical Association*, mental illnesses are "common and under-treated" in many countries, with the highest rate found in the U.S. Researchers conducted interviews with 60,643 adults from 14 countries to assess them for a range of mental illnesses, including obsessive-compulsive and panic disorders, bulimia, major depression, bipolar disorder, agoraphobia, post-traumatic stress disorder, and alcohol and drug abuse. Researchers then categorized countries as rich (U.S., Germany, Belgium, Italy, France, Spain, Japan and the Netherlands) or poor (Mexico, Colombia, Nigeria, Ukraine, China and Lebanon). Results show that in poor countries, about 80 percent of the serious cases of mental illnesses were untreated and in richer countries, between 35-50 percent of cases had not been treated in the last year. Researchers found that in all 14 countries, a substantial proportion of people with less severe cases received treatment, suggesting a "misallocation of treatment resources." The U.S. had the highest rate of people with mental illnesses at 26.4 percent, while Nigeria had the lowest rate at 4.7 percent. The most common disorders found everywhere except Ukraine were anxiety disorders, including panic attacks, phobias and post-traumatic stress disorder; mood disorders such as depression were most common in Ukraine. Researchers posit that the higher rate of reported mental illness in the U.S. may be linked to a greater willingness to discuss mental disorders.

END-OF-LIFE CARE

Assisted Suicide

On May 25th, a three-judge panel of the 9th Circuit Court of Appeals ruled that Attorney General John Ashcroft "far exceeded his authority" by interfering with the 1997 Oregon Death with Dignity Act. Under the Oregon law – the only one in the country – physicians may prescribe, but not administer, lethal prescription drugs to a terminally ill patient if the patient has decided to die voluntarily, can make health-care decisions, and has obtained agreement from two physicians that the patient has less than six months to live. In 2001, Ashcroft argued that the Oregon law violates the federal Controlled Substances Act. He issued a directive saying that assisted suicide served "no legitimate medical purpose," and warned physicians who prescribe controlled substances to assist in patient suicides that they could face criminal prosecution and license suspension or revocation. In a 2-to-1 decision, the panel ruled that the states, not the federal government, have the authority to regulate the practice of medicine, and that the Controlled Substances Act does not authorize the Department of Justice to override the Oregon law. The panel ordered an injunction that blocked Ashcroft's directive.

Conference Slate

✦ *Training Institutes 2004: Developing Local Systems of Care for Children and Adolescents with Emotional Disturbances and their Families: Early Intervention*, June 23-24, San Francisco, California. Hosted by the National Technical Assistance Center for Children's Mental Health at Georgetown University, the institutes will provide in-depth, practical information on how to develop, organize, operate, finance and sustain systems of care for children and adolescents with or at risk for emotional disturbances, and their families. Meeting topics include: early intervention and identification; community interventions involving youths and families; implementing, developing, financing and operating systems of care; systems of care in rural and urban communities; and serving children and adolescents with co-occurring mental health and substance abuse disorders and/or special needs. For more information call (202) 687-5000 or visit http://gucchd.georgetown.edu/institutes.html.

✦ *The Disease Management Colloquium*, June 27-30, Philadelphia, Pennsylvania. This executive education course will focus on the role of disease management in Medicare, Medicaid, health-care cost efficiency, quality and medical errors reduction. The colloquium seeks to educate government agencies, the health-care industry (including health plans and providers), employers and the general public about the important role disease management programs play in improving health-care quality and outcomes for persons subject to chronic conditions. Register online at http://www.dmconferences.com/registration.html or call (800) 546-3750.

✦ *Financing Long-Term Care: Politics, Policy and Practice*, June 23-25, Washington, D.C. The 17th annual conference hosted by the Long Term Care Educational Foundation will provide an opportunity for the public and private sectors to discuss ways the private market and government can work together to meet consumer needs and reduce public Medicaid costs. Attendees will include state and federal policy makers, long-term care providers and insurance industry representatives. For registration information, log onto http://www.ltcedfoundation.org/ or call (703) 968-8863.

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Of every dollar states spent on these disorders, 95.8 cents went to pay for public programs, including criminal justice, schools, Medicaid, child welfare, juvenile justice, mental health systems, highways, and state payrolls. Only 3.7 cents went to prevention, treatment and research.

This imbalance creates a paradox for legislators on health-care committees, said Henrik Harwood, PhD, vice president at Lewin Associates. Legislators can save money by increasing funding for treatment and prevention, but the savings won't show up in their budgets; the savings will come mostly from decreased spending on criminal justice. "A lot of the benefits that you would get for providing these services would occur in someone else's committee," Henrik said.

Still, some of the savings would be in health-care. "Alcoholics use ten times the number of medical services as non-alcoholics," noted McLellan. "Their families use five times the number of medical services (as families without alcoholics)."

While illicit drugs may get more "page one" headlines, alcohol is the substance most commonly abused. According to the 2002 National Survey on Drug Use and Health, one out of every two Americans over the age of 12 drinks; one of five is a binge drinker; and one of every 15, a heavy drinker. Approximately 19.5 million Americans (8.3 percent of the population) use illicit drugs.

SO WHAT CAUSES ADDICTION?

The key appears to be dopamine, a chemical in the brain that is linked to pleasure and survival, Volkow said. When dopamine cells, which are deep in the brain, are "fired" by some stimulus, they produce pleasure. But the cells also tell the brain that the factor that stimulated them was salient, or crucial to survival.

This recognition – that whatever triggered the dopamine response was crucial – helped humans to survive from prehistoric times to today. But it also contributes to the development of addiction. The drugs essentially tell the brain that *they* are essential for survival, Volkow explained.

Drugs increase the amount of dopamine in the brain to levels that are at least 10 times more intense than the levels that would be triggered by such common pleasures as viewing a beautiful painting or eating a bar of chocolate. After a while, the receptors that receive the "fired" dopamine become markedly dysfunctional, Volkow said. Stimulants that would normally trigger pleasure, such as the painting, do not produce a response.

"If you're addicted to drugs, and you have decreased receptors, the dopamine cells fire but the magnitude is not sufficient to produce a signal," Volkow said. "Drug-addicted people are no longer perceiving natural [stimulants] as salient, as motivating. . .But when they take a drug whose effects are ten times higher than natural [stimulants], these drugs will be able to activate the system, even though the receptors are decreased."

For the addict, natural stimulates are no longer pleasant or exciting – but drugs are highly stimulating. "Drugs of abuse have no competition," Volkow said. "We can chose among a variety of things, but for the addicted person, that is lost."

Addictive drugs also damage the part of the brain that enables us to control our actions, Volkow added. She recalled a judge who once told her, "'I understand that a person doesn't want to take the drug because they know that if they take the drug, they'll go to jail or they'll lose their children — and yet they take the drug.'"

What's happened, Volkow explained, is that the frontal cortex, which allows us to control our actions, has been enervated by dopamine. It has become dysfunctional. "This area of the brain is telling you, 'Brake, brake, brake, you have a tree in front of you,' Volkow said. "But you push the brakes, and if they don't function, what are you going to do? You're going to crash. Our ability to exert control over our desires is impacted."

THE PROBLEM WITH TREATMENT

"Curing" a person with a substance use disorder can be heartbreakingly difficult. According to some estimates, an addict will go through rehabilitation an average of seven times before they achieve abstinence.

But according to McLellan, our approach to treatment may be partly to blame. In groundbreaking research, McLellan compared addiction to other chronic illnesses, including hypertension, diabetes and asthma, and found stunning parallels. For example, fewer than 60 percent of people with hypertension take their medications regularly; fewer than 30 percent lose weight and exercise.

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Substance Abuse, from p. 5

Within 12 months, 50 to 60 percent have relapsed and have to be treated by a physician or in the hospital.

It's much the same with alcohol and substance use disorders. More than half of even court-ordered patients drop out of treatment, and 60 percent use drugs within six months of treatment discharge. McLellan said he realized, "Maybe we're going about this the wrong way. Maybe you're not going to get a life-changing experience in a single amount of time."

After all, he added, "you don't go from an acute-care cardiac unit to the street. That's malpractice." But that's essentially what we do with people who have substance use disorders: send them directly from detox or rehab to the street, with injunctions to remain sober.

Under the ideal model, an addict would go through in-hospital detox, residential rehab, outpatient treatment (such as group therapy), and then be monitored by a substance abuse specialist, who could, for example, telephone the patient regularly and send him or her back to outpatient treatment if a crisis appeared to be imminent. This system, which is being tested by some researchers, appears to be more successful in keeping people free of substance use.

"In chronic illnesses, the effects of treatment don't last very long after the care stops," McLellan said. "Patients who are out of the treatment context are at elevated risk for relapse. So we need to retain patients at an appropriate level of care and monitoring."

Unfortunately, he added, the only two widely available chronic care systems in the country for addicts are Narcotics or Alcoholics Anonymous, and methadone maintenance. These don't work for everyone, the waiting lists to get into methadone maintenance are long, and NA and AA don't have medical professionals monitoring patients.

"I'm not telling you that everybody with a substance use disorder needs chronic care," McLellan said. "And I'm not saying we've got to do more. . .It's a management perspective. . .It's a waste of your money to just hammer on people. You've got to do something that works, that's right."

WHAT TO DO, WHAT TO DO?

States have a variety of policy options available for dealing with this very difficult problem. Some have mandated that health insurers cover substance use disorders to the same extent that they cover other illnesses, others require that physicians rather than insurers determine medical necessity, some have expanded their Medicaid programs to cover adults with addictions, and others have used general revenue funds to supplement federally funded treatment programs.

A more recent trend involves reforming the criminal justice system so that it steers people with addictions into treatment, either in addition to – or instead of – incarceration. These reforms tend to fall into one of three categories: "diversion" programs (in which certain drug offenders are automatically diverted from prison or jail into treatment), drug courts (offenders work with judges and the prosecutor to create a plan for court-supervised treatment), and sentencing reforms (the sentence for certain drug offenses is reduced and in some states, treatment is required).

The thinking behind the reforms is that addicts who complete treatment are less likely to commit crimes again. The public is safer and the rate of increase in the costs of incarceration (and of social programs) is reduced. All states, some tribes, and the District of Columbia have set up drug courts. About 10 states use diversion. And a handful use sentencing reforms.

Among other efforts, Washington State has adopted sentencing reforms. In the late 1980s, the prison population was skyrocketing, due in part to stricter drug laws, said Ed Vukich, senior policy analyst of the Division of Alcohol and Substance Abuse in the state Department of Social and Health Services.

In FY 1985, drug offenders made up only 2.6 percent of the prison population; by FY 2003, that number had risen to 21 percent. Over the same time period, prison expenditures on drug offenders rose from $3.2 million to $89.1 million.

The prosecutors, the defense bar, Republicans and Democrats all agreed that major reforms were needed, and that those reforms should be treatment-based. "This is probably the only issue I have ever seen where everyone was on the same side," Vukich said.

Legislators devised a plan that under which offenders "pay their debt" to society *and* get treatment. Under the plan, passed in 2002, qualifying offenders agree to enter judicially supervised treatment in exchange for shorter prison sentences. If they don't complete treatment, they go back to prison and get the maximum sentence available.

The program went into effect in 2003. Subsidized with savings from reduced prison beds, the Criminal Justice Treatment Account provided $8.95 million in the first biennium, and $16.5 million in the second. Seventy-five percent of the dollars goes to the counties, and 25 percent to the state Department of Corrections.

Initial data show that post-reform prison sentences for drug offenders are shorter in length than those prior to the reform. However, the prison population is still increasing, due to factors beyond the scope of the reform, Vukich said.

"We treated 2,100 offenders in the first 10 months," said Vukich. He had expected to treat more, but says the program is having "growing pains." A "couple" of counties have stopped taking money from the Account because a growing number of treatment agreements have been revoked, and the prosecutors say there's no reason to give offenders an alternative if there's no way of making them stick to it, Vukich said.

"We're going to start research on treatment outcomes, such as length of stay in treatment and completion rates," Vukich said. "Contrary to popular belief, coerced treatment has the same outcomes as voluntary treatment." *CK*

This is part one of a two-part series.

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TRACKING *TRENDS*

From NCSL's HEALTH POLICY TRACKING SERVICE

States Restraining Medicaid Costs Through Private Insurance

An innovative long-term care program could help states restrain Medicaid cost increases, while protecting individuals from having to spend down their assets to Medicaid eligibility levels – that is, if the U.S. Congress can be persuaded to act.

In 1988, the Robert Wood Johnson Foundation (RWJ) launched the Partnership for Long-Term Care by awarding grants to four states – California, Connecticut, Indiana and New York. The states used the grants to create special private/public partnerships, combining private long-term care insurance with special Medicaid eligibility standards.

Under the partnerships, individuals buy long-term care policies and use the benefits until they run out. Once the benefits are used up, the individuals become eligible for Medicaid – but they don't have to spend down to the usual Medicaid income and asset limits. The individuals may either keep all of their assets or, depending on the state, keep more assets than they normally would in order to qualify for Medicaid. The partnerships thus relieve states of some of the costs of Medicaid, and they prevent people from having to divest themselves of all their assets.

Currently, only the four states that received the RWJ grants may offer these long-term care partnerships. That's because Congress in 1993 severely limited states' authority to joint venture with Medicaid, while grandfathering in the four original states.

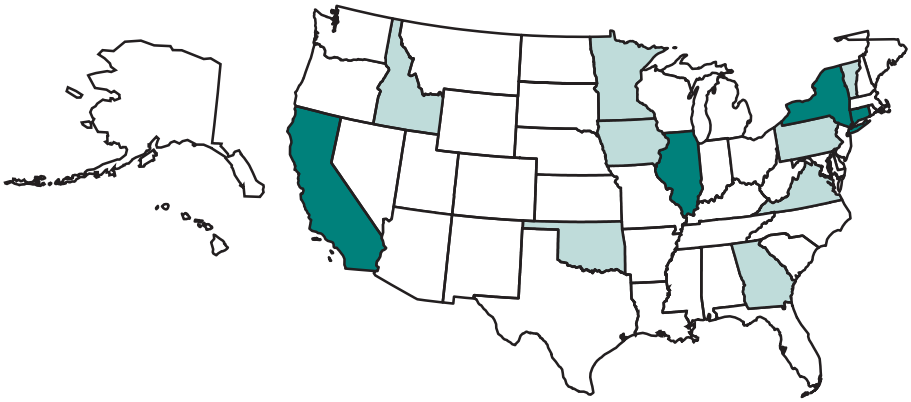
But other states would like to jump on that wagon. Currently, Idaho, Iowa, Georgia, Oklahoma, Pennsylvania, Vermont and Virginia are considering 28 bills pertaining to long-term care partnerships; five other bills have been passed and enacted. Most of this legislation authorizes the creation of partnerships if Congress removes the 1993 restrictions. Many states also have passed resolutions asking Congress to permit the partnerships. Minnesota lawmakers commissioned a report to determine whether the arrangements save money.

It's too soon to say what will happen, but U.S. Sen. Larry Craig (R-Idaho) has introduced legislation (S. 2077) to permit more states to enter into the pacts. There's companion legislation in the House. *–RT*

For more, go to www.hhp.umd.edu/AGING/PLTC/overview.html

For more information on this topic call (703) 531-1213 or e-mail info@hpts.org

Private/Public Partnerships



States that currently have long-term care partnership programs

States that are considering legislation and/or resolutions regarding partnership programs

FOR YOUR *INFORMATION*

Activists Fight to Give EMTs the Right to Administer Allergy Rx

Are you susceptible to food allergies? If so, you'd better hope that you live in a state where all EMTs (emergency medical technicians) are authorized to carry and administer epinephrine.

Twelve-year-old Kristine Kastner of Mercer Island, Washington., did not. Kastner, who suffered from a severe allergy to peanuts, died in 1998 after local EMTs were unable to administer her epinephrine during an allergic reaction. Kastner had gone into severe respiratory distress after eating a cookie with ground peanuts. At the time, Washington permitted only doctors, nurses and EMT-paramedics (the most highly trained EMTs) to give epinephrine. Kastner's death prompted Washington lawmakers to pass legislation allowing all EMTs to administer the life-saving medicine.

According to the Food Allergy & Anaphylaxis Network (FAAN), a non-profit advocacy group, about 11 million people in the U.S. – roughly one-in-25 – are believed to be affected by one or more food allergies. These allergies are responsible for approximately 30,000 emergency department visits and nearly 200 deaths each year. "Most people don't know how serious food-allergic reactions can be, or that it only takes trace amounts of food to cause a reaction," stated Anne Muñoz-Furlong, CEO and founder of FAAN.

The most extreme form of reaction to an allergen is anaphylactic shock. During anaphylactic shock, the throat and other mucous membranes itch and swell, blood vessels leak, and blood pressure drops, causing choking and collapse. Epinephrine (a form of adrenaline) relieves the symptoms by constricting blood vessels, relaxing muscles in the lungs to improve breathing, stimulating the heart beat and helping to stop swelling of the face.

FAAN is striving to ensure that all EMTs can legally administer epinephrine in all 50 states. Specifically, FAAN is targeting EMT-basics (those with the lowest level of training) because EMT-basics typically outnumber EMT-paramedics by two to one. EMT-basics also are often the first to arrive at the scene of a crisis. Since 1999, FAAN has collaborated with lawmakers, allergists and emergency medical services personnel to change the laws or regulations in 25 states.

Currently, FAAN puts only a minority of states in the "excellent" category, where all EMTs are authorized, or will soon be authorized, to carry and deliver epinephrine. In all the remaining states, there is still the risk that EMTs will respond to an anaphylactic emergency unequipped with or unable to administer the life-saving drug.

FAAN also works to raise public awareness and advance research on behalf of all those affected by food allergies. As part of its mission, FAAN observed May 9-15 as the seventh annual Food Allergy Awareness Week. Forty-five states participated, as did the District of Columbia. This year's theme was entitled *Prepare to ACT*: Avoid offending foods, Carry medications, Treat symptoms quickly. FAAN provided activity kits to local communities and organizations. One of the most popular of the week's events taught children and individuals how to save the lives of friends with food allergies; it was entitled *Be a PAL*: Protect A Life from Food Allergies program.

"Convincing others that food allergies are real and getting accurate information about food ingredients when eating away from home remain some of the most difficult challenges of living with the disease," said Muñoz-Furlong.

Ninety percent of food-allergic reactions are caused by eight foods: peanuts, tree nuts (pecans and walnuts, for example), wheat, fish, shellfish, soy, milk and eggs. While peanuts get a lot of publicity, a recent survey conducted by the Jaffe Food Allergy Institute and FAAN found that seafood allergies affect 6.5 million people – more than double the number of people with a peanut allergy. Unfortunately "there is no cure for food allergy," said Muñoz-Furlong. "Strict avoidance of the allergen is the only way to prevent a reaction."

Individuals should adhere to physicians' instructions and pay close attention to label ingredient information. Oftentimes, manufacturers may supplement ingredients without warning. Hidden ingredients such as milk, peanuts or peanut butter may be found in unsuspecting places. Suggestions would be to choose simply prepared foods and to inform management about food allergies prior to selecting a dish. ✦ *Written by Amanda Davis, intern with the Forum for State Health Policy Leadership.*

For more, see www.foodallergy.org

STATE HEALTH *NOTES*
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